Authorization to Release Protected Health Information

*Patient Name (Last, First) Nichols, Luis Diego *Date of Birth: 07/01/2006

*Phone Number: (520) 460-4234 Last four digits of Social Security Number: 9286

*Indicate when this authorization is to expire unless withdrawn or cancelled before then (*select only one*):

- ☑ Once the request is fulfilled
- ☐ On this specified date __/__/____
- ☐ On this event (*specify*): _____

The person named above is or has been a patient of:

*Name of Provider/Facility: _____ *City/State: _____

*Information about me that may be Released:

- ☐ Entire Health Record
- ☐ Billing Records
- ☐ Other (*specify*): _____

*Indicate applicable date(s) of service for the records to be released (If no dates are specified, records for any and all dates of service may be included):

_____

I understand that, under certain state laws, the categories indicated below cannot be released without my expli authorization. ***By initialing next to one or more of the categories of information listed below, I am providing th necessary explicit authorization to release records of that nature along with the records indicated above:***

- — Substance Abuse Prevention/Treatment
- — Mental Health Treatment/Psychotherapy Notes
- — HIV/AIDS Diagnoses and/or Treatment
- — Genetic Information
- — Sexual/Domestic Assault
- — Child Abuse/Neglect

*By signing my name below, I, Luis Diego Nichols (Patient/Personal Representative (*circle one*)), authorize the provider/facility named above or its agent to release the above indicated protected health information held by the provider/facility named above to the following party(ies):

☑ Other Grabb & Durando, PC 2929 E. Broadway Blvd. Tucson AZ 85716
(Name of Individual or Entity / Address / City / State / Zip Code)

*For the purpose of (check one): ☑ Legal Proceedings ☐ Claims Submission/Processing/Appeals

☑ Other (*specify*): personal injury claim

I understand that:

- I have the right to withdraw or cancel my authorization at any time but that my withdrawal or cancellation will not apply to the extend that action has already been taken on this authorization.
- If I withdraw or cancel this authorization, I must do so in writing to the Privacy Officer of provider/facility at PO Box 660031 Dallas, TX 75266.
- This authorization is voluntary and that the above named provider/facility may not condition my treatment, payment for treatment, eligibility for or enrollment in health benefits on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be redisclosed by the recipient(s) and no longer protected by federal privacy laws.

Luis Diego Nichols _____ __/__/____

Patient/Personal Representative Signature Date

If signed by someone other than the patient, please describe your authority to sign on behalf of the patient: _____

(*) indicates a required field